

MEDICARE COMPLIANCE

Adopting the Same Admission Criteria as RACs Is Expensive and Not Necessary

In their search for ways to shield themselves from the financial dangers of program-integrity reviews, hospital compliance officers are wondering whether to adopt the same inpatient admission screening criteria that are used by their recovery audit contractors (RACs). If they use InterQual and the RAC uses Milliman, maybe they should switch, and vice versa, but that can be an expensive move.

But CMS and an industry medical-necessity expert say that's unnecessary. This revelation will come as a big relief to hospitals that have been obsessing over this, especially in states like Iowa where the Medicare administrative contractor (MAC) uses InterQual, the quality improvement organization (QIO) uses Milliman, and the RAC plans to apply both sets of criteria.

A hospital's perception that it should use the same inpatient admission screening criteria as its RAC to review inpatient admissions has intensified as the national RAC program gets under way, says Joe Zebrowitz, M.D., executive vice president of Executive Health Resources, a Philadelphia firm that works with hospitals on medical-necessity compliance. "People are in a panic about this," he says. They think they're safer if they use the same admission screening criteria as their RAC, "but that's generally not the case."

The anxiety on this issue is understandable, since during the RAC demonstration CMS recouped hundreds of millions of dollars from hospitals in five states for alleged medically unnecessary inpatient admissions and inpatient services.

The InterQual versus Milliman debate may be beside-the-point. Marie Casey, deputy director of the CMS Division of Recovery Audit Operations, tells *RMC* that "the RAC statement of work does not mandate that a specific screening criteria be used in the review of claims. The RACs do have access to both InterQual and Milliman; however, a RAC would not deny a claim strictly based on the fact that the screening criteria indicates that the admission should not have occurred." Casey notes that InterQual and Milliman are only one tool in the RAC tool box. "These guidelines are not CMS-approved policy," she notes.

Zebrowitz agrees with CMS's position on the selection of screening criteria, and provides additional advice for hospitals in the process of choosing an inpatient screening tool or changing to a tool that matches its auditors. "Just because your RAC uses a particular screening tool doesn't mean you have to switch to that tool," he says, because InterQual and Milliman are only one method for determining medical necessity. However, "if a hospital is intent upon using the same screening criteria as a government contractor, it probably makes most sense to adopt one of the tools used by its MAC." Zebrowitz notes that MACs conduct prepayment and post-payment audits and rule on the first level of appeals in RAC overpayment determinations, while RACs do only post-payment audits.

Ultimately, though, whichever admission screening criteria hospitals embrace should have no bearing on a RAC or MAC denial. What matters is that hospitals use an evidence-based screening tool that's accepted by the medical staff "as a part of a compliant admission review process that includes secondary physician review as appropriate," Zebrowitz says. "If they have a compliant admission review process incorporated into the hospital utilization review plan and UR committee, and, if that compliant process results in the determination of inpatient admission status, then it is reasonable to assume that the provider could not have been expected to have known that the services were excluded from coverage at the time they were delivered."

Hospitals Protected Under Liability Provision

Given this, Zebrowitz states that the provider would meet the regulatory requirements of reasonable and necessary care and would be afforded the protections of the limitation on liability provision of Sec. 1879 of the Social Security Act (42 CFR 411.406(c) and (e)). In other words, hospitals could not have known their services were medically unnecessary if they qualify for this provision.

According to Zebrowitz, a compliant admission review process that provides limitation-on-liability protections should include:

(1) *The use of evidence-based inpatient screening criteria for the purpose of first-level admission review by a non-physician, which are accepted by the medical staff and incorporated into the hospital UR plan.*

While hospitals may use the screening criteria specific to a particular MAC, RAC or QIO, no requirement exists for providers, and this should not be the sole basis for intermediary denial. Zebrowitz says RACs would be hard-pressed to argue that a hospital should have known a claim lacked merit when the hospital, in good faith, used an evidence-based and industry accepted admission screening criteria tool as part of its process. If the RAC denies a claim based solely on the application of a different screening criteria tool but the hospital has a compliant admission review process, the hospital has an excellent basis for appeal. Zebrowitz further suggests that hospitals ensure they appropriately document their admission review process and create an auditable document trail to provide evidence of a compliant admission review process during the Medicare administrative appeal process.

(2) *The use of appropriate second-level physician review for the evaluation of cases that don't meet inpatient screening criteria requirements.* CMS states in Ruling 95-1 that medical-necessity determinations should rest heavily on evidence-based medicine. "Medicare contractors, in determining what acceptable standards of practice exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical

societies, and other health experts," the ruling says. This is CMS's way of saying that when physicians conduct the more subjective second-level reviews of medical-necessity decisions that won't fit squarely in InterQual or Milliman, they should turn to an evidence-based, literature-based medical expert opinion. "95-1 isn't easy to adhere to — it's not just one doctor's opinion of what a standard of care is. However, a good second-level physician review process that refers to appropriate clinical evidence and data will ensure you are able to clear that hurdle," Zebrowitz says.

There is another reason why hospitals using different admission screening criteria than their RACs do shouldn't switch. "Getting new criteria is a big commitment" — it involves additional organizational costs and requires investment in extensive training of case managers, Zebrowitz says. That's why adopting the MAC's method might be preferable. "MACs as a program are likely more stable," Zebrowitz notes. RACs may not last forever, but MACs will always be here to pay Medicare claims. MACs have already proven their appetite for medical-necessity reviews. For example, he says, MAC Trailblazer Health Enterprises, LLC recently did an audit of 250 elective cardiac stent procedures and said it found a greater than 98% error rate. "Hospitals rarely do admission reviews of stents," he says. "They are a perfect target, and the Trailblazer results suggest how aggressive the MACs can be."

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